BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

DAVID N. SMITH Claimant	)	
VS.	)	
TEMPLE-INLAND, INC. Respondent	)	Docket No. 1,025,963
AND	)	
INSURANCE COMPANY OF STATE OF PENNSYLVANIA Insurance Carrier	)	

ORDER

STATEMENT OF THE CASE

Claimant requested review of the October 22, 2007, Award entered by Administrative Law Judge Kenneth J. Hursh. The Board heard oral argument on January 23, 2008. Timothy M. Alvarez, of Kansas City, Kansas, appeared for claimant. Gary R. Terrill and Amber Jeffers, of Overland Park, Kansas, appeared for respondent and its insurance carrier (respondent).[1]

The Administrative Law Judge (ALJ) found that the impairment ratings given by both Dr. P. Brent Koprivica (17 percent) and Dr. Daryl L. Thomas (2 percent) were credible. He found that both ratings were based on deficits in ankle function and limited claimant's impairment to the lower leg. Accordingly, he found claimant's permanent partial impairment to be the mean of the two credible opinions, or 9.5 percent to the lower extremity at the 190-week level. The ALJ found there was not sufficient information in the record to determine why there was a $180 balance on the bill from Covenant and directed the parties to determine why there was a balance due. The ALJ stated that if the parties

[1] Respondent's brief shows the respondent as Inland Paperboard and its insurance carrier as ACE USA, but the Division's records show the respondent and its insurance carrier to be as listed in the above caption.

could not resolve this matter through further investigation, the expense should be addressed in a preliminary hearing.

The Board has considered the record and adopted the stipulations listed in the Award.

ISSUES

Claimant requests review of the ALJ's finding on the issue of nature and extent of his disability, arguing that Dr. Koprivica's disability rating is more credible than that of Dr. Thomas.

Respondent argues the issue of the nature and extent of claimant's disability should be affirmed. Respondent, however, argues the ALJ erred in requiring it to pay a bill in the amount of $180 because claimant did not provide evidence to substantiate that the bill was for authorized medical treatment or prove that the fee was appropriate based on the Workers Compensation Fee Schedule.

The issues for the Board's review are:

(1) What is the nature and extent of claimant's permanent partial disability as a result of his work-related accident of October 6, 2005?

(2) Did claimant fail to prove that respondent should be responsible for paying the $180 bill from Covenant?

FINDINGS OF FACT

Claimant is employed at respondent, a corrugation printing factory. He is an assistant operator of an EO66 dye cut machine. On October 6, 2005, claimant was attempting to clean out a sump pump pit while also running the dye cut machine. While doing so, the EO66 dye cut machine jammed. Claimant stepped out on a platform to remove the jam. As he stepped down, he lost his footing and fell into the sump pump hole. When claimant fell into the hole, his left foot and ankle hit a drain pipe. He did not fall all the way to the bottom of the sump pit. As soon as claimant hit the pipe, he knew he had been injured. He heard a loud pop, and the pain was blinding. He was taken to the hospital for treatment. X-rays were taken at the emergency room and showed claimant had no fractures. The only part of claimant's body that was injured was his left ankle.

While at the hospital, claimant was given pain medication, ice was applied, and he was given an air splint and crutches. He was diagnosed with a severe strain with possible torn ligaments and tendons. From the hospital, he was sent to OSH Comp Care (OSH) for treatment. He was treated at OSH for seven and a half weeks with physical therapy, ice

packs, an air splint, and exercises. During the time he was in physical therapy, he was unable to work.

Claimant was released to return to regular work on November 28, 2005. The last time claimant saw his physician, his ankle was doing better but was not back 100 percent. He was able to put weight on it and had better range of motion. However, he still had pain and swelling. When claimant returned to work, the repetitive getting up on and down off the machine, walking on rollers, and walking on concrete would cause his ankle to swell and become painful. Although he did not miss work after being released to return, he did take one week of vacation because of the pain.

Claimant was told by his physician to continue his exercises at home, continue using ice packs, and to use Ibuprofen. His physician wanted him to work an eight-hour schedule. It was claimant's understanding that the eight-hour work schedule would be a permanent restriction. However, the first week he returned to work, he worked about 55 to 60 hours. He continues to work 10 to 12 hour days.

Currently, claimant has constant pain in his ankle. It is a dull pain in the morning and then increases throughout the day. He also has swelling and reduced range of motion in his ankle. On a scale of 0 to 10, he described the pain as a 3 in the morning and a 5 or 6 by the end of the day. On the days he has to get up on and down off the machine at work often and the days he works a 12-hour shift, he has significant swelling. He still has swelling on days he does not work, but it is not as bad. He takes Ibuprofen three times a day every day for the pain and swelling in his ankle. He believes the condition of his ankle is staying the same, not getting better or worse. Claimant said he believes his left ankle is not as strong as his right, and he tries to protect it more than he does his other side.

Claimant met with Dr. P. Brent Koprivica, a certified independent medical examiner, on May 20, 2006, at the request of his attorney. Claimant complained to Dr. Koprivica of ongoing pain in the medial left hind foot and over the anterolateral left ankle ligamentous structures. He also complained that his ankle is weak, particularly weakness of foot dorsiflexion and plantar flexion. Claimant reported that his pain and swelling is worse at the end of the day.

Dr. Koprivica found that as a result of claimant's work-related injury of October 6, 2005, he sustained a severe injury to his left lower extremity. He noted that claimant had a marked limp on the left when he attempted toe and heel ambulation. Claimant had weakness in his left ankle. Dr. Koprivica diagnosed claimant with injury to his posterior tibialis tendon with ongoing chronic tendinitis. Claimant also had an injury of the anterior talofibular ligament with ongoing pain. Dr. Koprivica opined that the injury involved the entire left leg with evidence of atrophy in the calf and in the left thigh and, therefore, claimant's level of impairment should be to the entire lower extremity.

Using the AMA *Guides*,[2] Dr. Koprivica rated claimant as having a 17 percent left lower extremity at the level of the hip for the October 6, 2005, injury. He explained that the consequence of this injury is demonstrated at the hip.

Dr. Koprivica believed that the assignment for impairment for weakness for plantar flexion of the ankle to be representative of the overall impact of the injury. In that regard, he believed claimant had a 24 percent foot impairment, which converts to a 17 percent lower extremity impairment. Using this as a reference, he stated that a similar level of impairment would be assigned based on atrophy of the calf and left thigh, and he rated claimant as having a 17 percent of the left lower extremity at the level below the hip.

Dr. Daryl Thomas, who is board certified in internal medicine and is also a certified independent medical examiner, examined claimant on April 17, 2007, at the request of respondent. Claimant reported to him that he had constant pain of intermittent intensity. An MRI showed a strain of the posterior tibialis tendon and the lateral ligaments about the ankle.

After examining claimant, Dr. Thomas diagnosed him with an ankle sprain. He found that claimant had a decrease in the range of motion of the ankle based on the left ankle inversion, but no weakness of the ankle. Based on the AMA *Guides*, he rated claimant as having a 3 percent permanent partial impairment of the left foot, which converted to an impairment of the left lower extremity of 2 percent.

Dr. Thomas did not take any measurements of the thigh, knee or calves to check for atrophy. He testified that he would not expect a person with an ankle injury to have significant atrophy in the calf. If there was atrophy, there would most likely also be weakness. He also opined that the farther away the atrophy is from the site of the injury, the more likely it is unrelated.

Claimant received in the mail a bill in the amount of $180 from a collection agency for Covenant. Claimant does not know what this bill was for. However, the date of service was October 6, 2005, and the only medical treatment he received that day was for injuries suffered in this accident.

PRINCIPLES OF LAW

K.S.A. 2006 Supp. 44-501(a) states:

> If in any employment to which the workers compensation act applies, personal injury by accident arising out of and in the course of employment is caused to an

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[2] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are based upon the fourth edition of the *Guides* unless otherwise noted.

> employee, the employer shall be liable to pay compensation to the employee in accordance with the provisions of the workers compensation act. In proceedings under the workers compensation act, the burden of proof shall be on the claimant to establish the claimant's right to an award of compensation and to prove the various conditions on which the claimant's right depends. In determining whether the claimant has satisfied this burden of proof, the trier of fact shall consider the whole record.

K.S.A. 2006 Supp. 44-508(g) defines burden of proof as follows: "'Burden of proof' means the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record."

The burden of proof is upon the claimant to establish his right to an award for compensation by proving all the various conditions on which his right to a recovery depends. This must be established by a preponderance of the credible evidence.[3]

K.S.A. 2006 Supp. 44-510i states in part:

> (c) The director shall prepare and adopt rules and regulations which establish a schedule of maximum fees for medical, surgical, hospital, dental, nursing, vocational rehabilitation or any other treatment or services provided or ordered by health care providers and rendered to employees under the workers compensation act and procedures for appeals and review of disputed charges or services rendered by health care providers under this section.
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> . . . .
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> (e) All fees and other charges paid for such treatment, care and attendance, including treatment, care and attendance provided by any health care provider, hospital or other entity providing health care services, shall not exceed the amounts prescribed by the schedule of maximum fees established under this section or the amounts authorized pursuant to the provisions and review procedures prescribed by the schedule for exceptional cases. . . .

K.A.R. 51-9-7 states:

> Fees for medical, surgical, hospital, dental, and nursing services, medical equipment, medical supplies, prescriptions, medical records, and medical testimony rendered pursuant to the Kansas workers compensation act shall be the lesser of the usual and customary charge of the health care provider, hospital, or other entity providing the health care services or the amount allowed by the "workers compensation schedule of medical fees" published by the Kansas department of labor and dated December 1, 2005, including the ground rules incorporated in the schedule, which is hereby adopted by reference.

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[3] *Box v. Cessna Aircraft Co.*, 236 Kan. 237, Syl. ¶ 2, 689 P.2d 871 (1984).

K.A.R. 51-9-10 states in part:

(a) Upon the completion of treatment in all compensation cases, physicians shall promptly notify the employer or carrier, and shall render their final bills forthwith. Bills for medical care providers and hospitals shall be itemized showing the date and the charge for services rendered. Separate bills should be presented to the employer or carrier by each surgeon, assistant, anesthetist, consultant, hospital, or nurse. In cases requiring prolonged treatment, physicians should submit partial bills, fully itemized, at intervals of at least 60 days.

(b)(1) Medical reports of the physician should be submitted on a periodic basis depending upon the nature and severity of the injuries involved and, in all cases, immediately upon request of the respondent or insurance carrier. A report shall be rendered on the date on which the physician releases the worker to return to work and forwarded to the employer or insurance carrier and to the employee, if requested.

. . . .

(3) The patient privilege preventing the furnishing of medical information by doctors and hospitals is waived by a worker seeking workers compensation benefits, and all reports, records, or other data concerning examinations or treatment shall be furnished to the employer or insurance carrier or the director at that individual's request without the necessity of a release by the worker.

K.S.A. 44-510d(a) states in part:

(a) Where disability, partial in character but permanent in quality, results from the injury, the injured employee shall be entitled to the compensation provided in K.S.A. 44-510h and 44-510i and amendments thereto, but shall not be entitled to any other or further compensation for or during the first week following the injury unless such disability exists for three consecutive weeks, in which event compensation shall be paid for the first week. Thereafter compensation shall be paid for temporary total loss of use and as provided in the following schedule, 66 2/3% of the average gross weekly wages to be computed as provided in K.S.A. 44-511 and amendments thereto, except that in no case shall the weekly compensation be more than the maximum as provided for in K.S.A. 44-510c and amendments thereto. If there is an award of permanent disability as a result of the injury there shall be a presumption that disability existed immediately after the injury and compensation is to be paid for not to exceed the number of weeks allowed in the following schedule:

. . . .

(15) For the loss of a lower leg, 190 weeks.

(16) For the loss of a leg, 200 weeks.

. . . .

(18) Amputation or severance below the wrist shall be considered as the loss of a hand. Amputation at the wrist and below the elbow shall be considered as the loss of the forearm. Amputation at or above the elbow shall be considered loss of the arm. Amputation below the ankle shall be considered loss of the foot. Amputation at the ankle and below the knee shall be considered as loss of the lower leg. Amputation at or above the knee shall be considered as loss of the leg.

It is the situs of the resulting disability, not the situs of the trauma, which determines the workers' compensation benefits available.[4]

ANALYSIS

The parties presented the opinions of two medical experts. Respondent hired Dr. Thomas to examine claimant and provide an impairment rating, and claimant hired Dr. Koprivica to do the same. The physicians agreed that the AMA *Guides* provide three methods for measuring impairment, weakness, atrophy, and range of motion. Dr. Thomas testified that claimant's permanent impairment was 2 percent of the leg using the range of motion method. Dr. Koprivica testified that claimant's permanent impairment was 17 percent to the leg using either the weakness method or the atrophy method. In this case, he considered these numbers to more accurately measure claimant's impairment than the range of motion method. The parties introduced into evidence a portion of the AMA *Guides*.[5] Contained within that portion of the AMA *Guides* placed into evidence is the following:

> The impairment from weakness is judged to be of greater significance to the patient than the atrophy impairment. Thus, manual muscle testing . . . is the better approach to estimating the patient's impairment.[6]

The Board finds claimant's permanent partial disability is 17 percent to the leg. Dr. Koprivica further testified that claimant's atrophy and resulting weakness impairment extended to the thigh. As this is above the knee, claimant's impairment is at the 200 week level.

Respondent arranged for claimant to be taken to Providence Medical Center. While there, he was referred to OSH Comp Care. Claimant testified that the only treatment he received on October 6, 2005, was for his work-related injury. Respondent is liable for the cost of claimant's treatment of October 6, 2005, subject to the medical fee schedule. The ALJ's Award is affirmed in this regard.

CONCLUSION

Claimant has a 17 percent impairment to his left leg.

Respondent is ordered to pay all reasonable and related medical expenses subject to the medical fee schedule.

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[4] *Bryant v. Excel Corp.*, 239 Kan. 688, 692, 722 P.2d 579 (1986); *Fogle v. Sedgwick County*, 235 Kan. 386, 680 P.2d 287 (1984).

[5] Thomas Depo., Ex. 1; Koprivica Depo., Ex. 3.

[6] AMA *Guides* at 3/77.

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award of Administrative Law Judge Kenneth J. Hursh dated October 22, 2007, is modified to find claimant has suffered a 17 percent permanent partial disability to his leg but is otherwise affirmed.

Claimant is entitled to 7.57 weeks of temporary total disability compensation at the rate of $467 per week in the amount of $3,535.19, followed by 32.71 weeks of permanent partial disability compensation, at the rate of $467 per week, in the amount of $15,275.57 for a 17 percent loss of use of the left leg, making a total award of $18,810.76, all of which is due and owing and ordered paid in one lump sum minus any amounts previously paid.

IT IS SO ORDERED.

Dated this _____ day of January, 2008.

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BOARD MEMBER

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BOARD MEMBER

_____
BOARD MEMBER

c: Timothy M. Alvarez, Attorney for Claimant
Gary R. Terrill, Attorney for Respondent and its Insurance Carrier
Kenneth J. Hursh, Administrative Law Judge